PERSONAL DATA FORM
ND DEPARTMENT OF HUMANS SERVICES
VOCATIONAL REHABILITATION
SFN 93 (Rev. 04-06)

Name:	Maiden/Other Name:
Address 1:	
Address 2:	
City, State, Zip Code:	E-Mail:
County of Residence:	Telephone Number: ( )

Social Security No:	Date of Birth: Month Day Year	Sex: ___ Male ___ Female

Race/Ethnicity (Select all that apply):

___ White/Caucasian
___ Black/African American
___ American Indian or Alaska Native
___ Asian
___ Native Hawaiian or Other Pacific Islander
___ Hispanic or Latino Note: If this is selected, at least one of the above must also be selected.

Work Status (Select only one):

* ___ Employed without Supports in Integrated Setting [1]
* ___ Employed with Supports in Integrated Setting [11]
* ___ Self-employed (except BEP) [3]
* ___ State Agency-managed Business Enterprise Program [4]
* ___ Extended Employment [2]
___ Homemaker [5]
___ Unpaid Family Worker [6]
___ Not employed: Student in Secondary Education [10]
___ Not employed: All Other Students [7]
___ Not employed: Trainee, Intern or Volunteer [9]
___ Not employed: Other [8]

Highest Level of Education Attained (Select only one):

___ No formal schooling [0]
___ Elementary education (grades 1 - 8) [1]
___ Secondary education, no high school diploma (Grades 9-12) [2]
___ Special education certificate of completion/ attendance, received special education but no certificate, currently in special education [3]
___ High school graduate or equivalence certificate (GED) (regular education students) [4]
___ Post-secondary education, no degree [5]
___ Associate degree or Vocational/Technical Certificate [6]
___ Bachelor's degree [7]
___ Master's degree or higher [8]

Have you ever received services under an Individualized Education Program (IEP)?
____ Yes ___ No

Number of Dependents
(Do not count yourself):

* If selected,
Hours worked last week:

If Hours entered,
Earnings last week: $

For Office Use Only:
Referral Date: _____
Counselor: _____
Disability at Referral: _____

Primary Source of Support (Select only one that represents your largest single source of economic support):

- ☐ Personal Income (earnings, interest, dividends, rent) [99]
- ☐ Family, Friends (includes earnings of spouse, or spouse's unemployment insurance checks) [01]
- ☐ Public Support (SSI, SSDI, TANF, etc.) [03]
- ☐ All Other Sources of Support (e.g., private disability insurance and private charities) [10]

Living Arrangement (Select only one):

- ☐ Private Residence [99]
- ☐ Mental Health Facility [04]
- ☐ Community Residential/Group Home [05]
- ☐ Substance Abuse Treatment Center [07]
- ☐ Deaf School or Other Inst. for the Deaf [10]
- ☐ Rehabilitation Facility [11]
- ☐ Nursing Home [13]
- ☐ Halfway House [14]
- ☐ Adult Correctional Facility [15]
- ☐ Homeless/Shelter [18]
- ☐ Other [17]

Please Indicate if you are a:

- ☐ Veteran
- ☐ Migrant or Seasonal Farmworker

Source of Referral (Select only one):

- ☐ Educational Institution (elementary/secondary) [14]
- ☐ Educational Institution (post-secondary) [10]
- ☐ Community Rehabilitation Program [30]
- ☐ Medical Personnel, Institution, or HSC [32]
- ☐ Public Welfare Agency (State or local govt.) [40]
- ☐ Private Welfare Agency [44]
- ☐ SSA (DDS or district office) [50]
- ☐ Workers' Compensation Agency [52]
- ☐ One-stop Employment/Training Center [53]
- ☐ Correctional Institution, Court, Officer [56]
- ☐ Employer [62]
- ☐ Self-referral [70]
- ☐ Other [79]

Do you have Medical Coverage? ☐ Yes ☐ No If Yes, select all that apply:

- ☐ Medicaid
- ☐ Medicare
- ☐ Workers' Compensation
- ☐ Private Insurance Through own Employment
- ☐ Private Insurance Through other Means (Name of Company) _____

Type of Public Assistance I am Now Receiving (Select all that apply):

- ☐ None
- ☐ TANF..... Amount $ _____ / Month
- ☐ SSI ..... Amount $ _____ / Month

SSI Start Date _____

SSI Stop Date _____

- ☐ Social Security Disability Insurance (SSDI). . . . . Amount $ _____ / Month

SSDI Start Date _____

SSDI Stop Date _____

- ☐ General Assistance (GA) ..... Amount $ _____ / Month
- ☐ Veterans Disability (VA) ..... Amount $ _____ / Month
- ☐ Workers Compensation..... Amount $ _____ / Month
- ☐ Other Public Support..... Amount $ _____ / Month

List of Family Members in Your Home Now				
Name	Age	Relationship	Education	Employment

Name of individual (other than spouse) who will always know your address and/or telephone number:	
Name:	
Address:	
City, State, ZIP	Phone Number

Education	
Last School Attended:	
Other Training:	
Aptitude or Interest Tests You Have Taken:	
Where:	When:

Employment History			
Employer	**Nature of Work**	**Dates**	**Weekly Earnings**
Are you registered with any Employment (Job Service) Office?		Where:	
I would be interested in working (Field of Work):			

Agency Contacts	
I have contacted the following agencies within the past year:	
Agency	**Location**
___ Job Service Office	
___ Human Service Center	
___ Social Security Office	
___ County Social Services	
___ Private Welfare Agency	
___ Veterans Administration	
___ Workers Compensation	
___ Other	

Medical Services	
I have received medical services at the following: (Name/dates of visit to hospital, clinic or doctor):	
1	Date:
2	Date:
3	Date:
4	Date:
5	Date:

Please describe how your disability affects your activity: